Attachment One
MCP Operational Manuel

Billing Scenarios

I. GENERAL BILLING

1. Routine Labs - Hematocrit (85014), hemoglobin (85018), chemical/routine urinalysis (81000 - 81050) are covered through the maternity global fee. Note: If these sevices are provided as part of an ER visit, they can be billed fee for service.

2. Miscarriage

Claims containing a miscarriage diagnosis code can be sent directly to EDS through the normal billing process. Providers have the option of adding a miscarriage diagnosis code to a claim that was originally provided for a routine service. Claims for services that are provided for a woman that subsequently miscarries that do not have a miscarriage code must be sent to the Primary Contractor for administrative review. Miscarriage diagnosis codes are 630-635, 637-639, 666.2.

3. Outpatient Visits

Visits to the outpatient facility (e.g. emergency department - ED) are covered fee for service. There may be certain services that are the responsibility of the Primary Contractor such as ultrasounds. Other lab, x-ray, etc. services that are provided and that are not part of the global can be billed to EDS. Note: If a patient is coming in through the ED and is sent to Labor and Delivery, then a claim cannot be submitted. Fee for service outpatient codes are: 99281-99285

4. Inpatient Admissions at Non-subcontracted Hospitals

A. When a Medicaid recipient presents for an emergency admission or delivery at a non-subcontracted hospital, the Primary Contractor is responsible for paying the hospital, the delivering physician and other providers involved in the delivery at a rate not to exceed what Medicaid would have paid. The non-subcontracted hospital should notify the Primary Contractor within 24 hours that the person has been admitted. When the patient's condition has stabilized, they may be transferred to a subcontracted hospital.

B. When a patient is admitted for a non-emergency type reason (urinary tract infection), the non-subcontracted hospital should contact the Primary Contractor for further instruction within 24-48 hours of admission. The Primary Contractor is not responsible for reimbursing for services if they were not notified or contacted by the non-subcontracted hospital.

5. Sterilization

When a physician performs a sterilization procedure during delivery admission or at any time in the covered postpartum period, this can be billed fee for service to

Medicaid. The claim should be sent directly to EDS with a copy of the sterilization consent form attached. If done at the time of a C-section delivery, the diagnosis code used should be V25.2, with procedure code 58611. A multiparity diagnosis code may also be used. Additional claims for hospitalization cannot be submitted.

A. An additional claim for anesthesia services cannot be submitted if the tubal ligation is done at the time of delivery unless the claim documents when the anesthesia for the tubal began. A claim for total anesthesia can be submitted if the tubal is done at a later date. This practice will be monitored.

B. For SOBRA eligible recipients who have had a tubal ligation and present for an outpatient visit or required readmission due to complications secondary to this procedure, the correct diagnosis code to be used is 998.9 (unspecified complication of procedure, not elsewhere classified). These claims can be submitted directly to EDS for consideration.

C. Inpatient claims for sterilization done at the time of delivery may not be submitted. Hospitals may bill inpatient claims for sterilizations performed at a later date.

6. Administrative Review Form

The Administrative Review Form must be completed anytime a claim is being sent to the Agency for review. Any claim received by a subcontractor that is not accompanied by the Administrative Review Form will be returned to the Primary Contractor for that district.

II. BILLING SCENARIOS

To help Primary Contractors and subcontractors understand the what and when of billing, below are listed some common scenarios. If at any time there is a question on billing, please call the Maternity Care Program. These questions were taken from actual scenarios submitted.

1. Q. A patient is receiving care from a subcontractor. She goes into early labor, and the physician decides she needs to be transferred to a Level B facility. The family insists that she be transferred out of the network, and the physician agrees to this transfer. How should the billing be handled since the physician transferred her? How is the physician and hospital to be paid? How would the billing be done if the patient arbitrarily went to a Level B outside of the network without a physician transfer? How is the physician and hospital to be paid?

   A. If a physician within your provider network transfers a patient to a non-subcontracting hospital, the Primary Contractor is responsible for reimbursing the non-subcontracting physician and hospital.

2. Q. Patient applies and is approved for SOBRA Medicaid when patient is 7 months pregnant. Patient is already being seen in doctor's office. What services are expected from Primary Contractor?

A. The Primary Contractor should make sure that all program requirements are being met either through the private physician's office or the clinic, including care coordination. If the physician is not a subcontractor, then an exemption may be granted if the patient can document why she delayed in applying for Medicaid.

3. Q. While waiting for program exemption approval, the patient was seen by Primary Contractor subcontractors. How do we bill and when?

A. All services are billed fee for service once exemption is approved.

4. Q. Could you give some type of guidelines as to when you should be able to bill the global delivery fee versus the delivery only fee. For example a patient has been compliant, began prenatal care at 10 weeks gestation delivered at 37 weeks gestation but only received 6 prenatal visits and 2 case management visits. What if a patient began care at 27 weeks gestation delivered at 38 weeks received 6 prenatal visits but only 1 or 2 case management visits?

A. The global fee should be billed when a woman has received some or all of her prenatal care through the Primary Contractor's network and has been enrolled. When a woman only presents at the time of delivery, then the delivery only fee should be billed. If the patient has been receiving care but has not become Medicaid eligible until time of delivery, then the Primary Contractor could bill the delivery only fee and the providers of service up until that point could bill the patient for services provided during the antepartum period.

5. Q. Are UCG's (pregnancy tests) covered under the global fee? If not, should private or other service providers bill the Primary Contractor for this test? If a patient goes to the emergency room and is diagnosed as pregnant, is the Primary Contractor responsible for reimbursement?

A. UCG's can be billed fee for service. The lab code for the pregnancy test should be filed to EDS. The visit to determine pregnancy however may be part of the expanded global fee if the provider is a subcontractor and it is a prenatal visit.

6. Q. If the patient is referred to a non-subcontracted hospital such as UAB and stays several days but delivery is at a subcontracted hospital, how is the UAB hospital paid?

A. The non-subcontracted hospital is paid by the Primary Contractor.

7. Q. A SOBRA patient delivers January 28th and has pregnancy related problems which continue unresolved past her SOBRA eligibility. Can the services be covered?

A. Once the patient's Medicaid eligibility ends no additional services can be billed; however, the provider should try to resolve the condition to the best of their ability.

8. Q. How should an at-home delivery be billed if the patient presents to the hospital immediately after delivery and has had no prenatal care?

A. Bill the delivery only fee and pay the hospital and physician providing delivery and post partum care.

9. Q. If a patient does enroll in the Maternity Care Program of a district and has some care in that district then delivers in another district, is that when the dropout is billed? Would anyone bill the global?

A. The district with whom the patient began care would bill the dropout fee and providers of service would file their claims through the Administrative Review process. The "new" district would submit the appropriate global claim depending on services received. It is suggested that dropout claims be held until the EDC due to possibility of the patient returning to the original district.

10. Q. When would a Primary Contractor pay providers of another district for services rendered?

A. If the patient were sent by an in-district provider to an out of district provider for some aspect of care.

11. Q. If a patient presents for delivery, does the patient have to be admitted to the program in order to bill a delivery only fee:

A. Basic patient information should be gathered. It is not necessary that actual enrollment (signing of Agreement to Receive Prenatal Care) is accomplished.

12. Q. If a patient received care in the system but doesn't show up for enrollment in the program, at what point can you stop contacting the patient for admission?

A. At least two attempts should be made to contact the patient. It is recommended that the 2nd attempt be a certified return receipt letter.

13. Q. How is third party billing accomplished?

A. If a woman has TPL, then individual providers of service should bill the third party carrier. Monies received should be reported to the Primary Contractor. The Primary Contractor in turn should deduct the amount that would have been paid through the program from the global and submit the difference to EDS.